

General Comments

Behavioral Health Integration: Public Comments Form

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Commenter: de-identified

Organization:

Date:

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☐ Evaluation and Data
- ☐ Chronic Health Home

Comment: I am a current Practice Change Fellow whose project in on integrating somatic and psychiatric care in the elderly. I hope your committee includes frontline general medicine clinicians. Pediatricians also should be involved as many adolescents have depression/substance abuse issues. There needs to be community health workers/case managers to follow-up with these patients between office visits.

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Comment: The model should best ensure maximizing of self-efficacy and ongoing health education across the life span.

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Comment: This is about Model #3 of the three proposed potential models. As Mr. Milligan stated repeatedly at the meeting earlier this week, the Department did not receive comments on that model in the first official public comment period. Speaking on behalf of NCADD-Maryland, the organization did not make any comments because it only has questions. So here they are:

- Are there examples in other states where this kind of model has had successful health outcomes?

DHMH Response: This is a relatively new model. It is being implemented in Maricopa Arizona (Phoenix area) and in New York City. It shows promise for providing comprehensive care to a high risk targeted population. Although we know of no long term projects such as this with SPMI populations, the PACE program which is a nationwide program that provides comprehensive care to adults who meet nursing home level of care has been a highly successful program.

- Are there any examples of high-risk specialty MCOs having successful outcomes in health and having been affordable?

DHMH Response: The State would have to develop rate setting to ensure that the rates are robust enough to serve the population. The PACE program combines Medicare and Medicaid

funding. These programs have been successful in serving high risk populations and remaining in business.

- What is the level of consumer choice envisioned in this model? Will folks with specific diagnoses automatically be put into this specialty BHO? Will folks be able to opt in if they have less serious diagnoses but want the specialty?

DHMH Response: Stakeholders could have input into these issues. With the Rare and Expensive Case Management program, folks do need to meet the diagnostic criteria to enter the program. However, if they choose, they can instead enroll with one of the seven MCOs. Most individuals select REM, but there are a significant number who choose to remain in fee-for-service.

- When someone's behavioral health problems are successfully addressed and the person's health improves, will the person need to change MCOs and possibly providers? Will they be able to re-entry the specialty BHO if they relapse or have some reoccurrence of their diagnosis?

DHMH Response: It was our assumption, that individuals with SPMI or chronic SUD could remain in the specialty BHO/MCO even if their health improved. The goal is to stabilize and improve health so it would not make sense to force disenrollment once that occurs. On the other hand, stakeholders can comment on whether individuals can choose to leave the specialty BHO/MCO and enroll in one of the other general MCOs.

- Will the "specialty" of this BHO be defined by additional case management benefits and/or a broader array of wrap-around services?

DHMH Response: It would make sense that the specialty BHO/MCO would be given additional resources such as those necessary to implement a chronic health home. The specialty BHO/MCO would have the full array of all current services. Stakeholders can comment on whether there are additional wrap-around services which will result in better outcomes for this population.

It is difficult to have any idea if this model would be appropriate without some of these, and possibly other questions from smarter people being answered. Where will details about this model be discussed so stakeholders can provide informed feedback?

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Comment: Because of the fee-for-service nature of the Public Mental Health System that was implemented in 1997, there is a good sense of the probable increase in the demand for and cost of services as the population eligible for Medical Assistance increases. The grant based system that has been used for reimbursement for substance use services has not provided that same level of demand based data. How would the need for and cost of substance use services for the MA population be determined to establish the "protected" premium in model 1 or for the behavioral health service system in model 2? Is it not possible and perhaps likely that the premium for substance use services will be understated if it is based on historical MA data and that resources that go into the system as a result of the better known demand for mental health services will have to be used to pay for substance use services?

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Comment: There has been a consistent reference to legislative changes being made if they are necessary. Given that the provisions of the Specialty Mental Health System are in legislation, regulation, and the 1115 waiver document, and given that it has been made clear that the current system will not continue, why would there be any question of whether legislative as well as regulatory and waiver application changes are necessary?

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Comment: Services need to be covered to best serve the patients. One fear with a model other than FFS is that services that should be reimbursed are not for some reason or another. But we support a model that leverages Medicaid money as much as possible and that covers all levels of care.

Further, in an outcomes-based payment system, the rates must reflect the expenses providers incur that are not directly related to treatment, but are nonetheless necessary and make treatment possible. If these aren't factored into the model, smaller providers will be hurt significantly.

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It is of considerable concern to mental health consumers that an integrated system will lose some of the strengths of our current system. Patient focus with choice of providers is difficult to maintain in a closed panel managed care organization. Must allow open participation for all providers both public and private.

As a consumer wellness and recovery center we are very concerned that our time funding for essential peer support services and consumer activities will be difficult to fund and maintain. Study over the past year has indicated that fee for service for peer support will not cover much of the current consumer activities in MD. If the summer conference is as valuable as we believe, how will funding be protected over the longer term? How will services to non-Medicaid Marylanders with mental health needs be maintained?

How will mental health advocacy activities be a focus in a new world where all services are integrated? Maryland's advocacy organizations are really strong and need to continue.

Integration of mental health, behavioral health S.A., and somatic health is critical to improving consumer health status. This must be accomplished without taking away the advantages of the current carve-out.

Systems Linkage Comments

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Comment: In response to your request for written comments to better inform the activities of the Systems Linkage Options Workgroup, we are submitting the document entitled, The Ideal Substance Use Disorder Treatment System in Maryland. The document was developed, refined and updated by substance use disorder treatment providers throughout the state to clearly outline what should be included in an ideal system for treatment of substance use disorders in Maryland.

Please use this document as you examine system linkage options and begin developing an integrated and responsive behavioral health system. If you have any questions, please contact us.

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State/Local Role and Non-Medicaid Comments

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Comment: I raised this question at the last large group meeting and did not get a response to it. There is currently a clear distinction between those services funded through Medical Assistance and state only funded services. The planning for the financing, managing and monitoring of these services is one major charge of this workgroup. However, there are currently several mental health services in the Medical Assistance benefit that are unlikely to be included in the baseline benefit defined by the Exchange. These services are certainly not included in the plans from which the Exchange is charged with making its selection. Will that mean that these services will not be part of the Medical Assistance benefit? Will Maryland forego the federal match for these services and covert them to State funded services? I am not sure that I understand how is it possible for this workgroup to carry out its charge if the question of how (and perhaps if) these services are to be funded after the implementation of whatever model is adopted really remains undefined?

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Comment: I think it is important to clarify the scope of the state/local role and non-Medicaid services workgroup, and differentiate between:

- Services not funded by Medicaid
- Services for non-Medicaid-eligible individuals
- Functions that should occur on the state and local level and the role of local behavioral health authorities

The merging of the state/local role workgroup and the non-Medicaid services workgroup suggests -- erroneously -- that the local role is primarily focused on non-Medicaid services. In fact, the state's core service agencies are very involved in a diverse range of activities over and above their funding of non-Medicaid services. They include many oversight and management functions relating to Medicaid-funded services. In addition, core service agencies have a history of creating new programs through innovation and serving as system-level partners with local education, social service, juvenile justice and criminal justice systems, LMBs, health departments, police, etc. If the workgroup scope includes a focus on the role of Maryland's local behavioral health authorities, then now or once the financing model is selected, Maryland should look to the experience of other states that have implemented a similar financial model, and examine those which have established effective local behavioral health authorities.

Finally, a consideration of non-Medicaid services would be best done in a manner that includes both Medicaid-eligible and non-Medicaid-eligible individuals, since people move between these categories, yet their need for housing and other non-Medicaid-funded services remains constant.

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Evaluation and Data Comments

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Comment: A number of data requests were put forward at Tuesday's BHI State/Local/NonMedicaid Workgroup meeting. Summarized below are data elements that the Mental Health Association recommends as helpful in informing the work of this committee:

- Can we get a county by county analysis of the non Medicaid funded services that are offered in mental health and addictions (variability of offered services is significant from county to county, and it would be helpful to see a matrix which itemizes the services provided in both systems at the local level)
- Can we get an itemization of how these services are funded in each jurisdiction (by local government, government or private sector grants, or other means) and specifically how much funding is provided by local government in each jurisdiction (mental health core service agencies have already collected some of this information in the past and may be able to quickly update or refine existing documents)
- If we are to be examining and recommending restructuring of the local government entities that oversee behavioral health delivery, can DHMH provide:
 - o An environmental scan of how local government is organized to manage these services in other states; analysis of these systems and information about effective or promising initiatives that are underway in other states
 - o A summary and analysis of possible structural options for Maryland to consider that stakeholders can review and respond to

It was unclear from the discussion whether the purview of the workgroup is broad (are we examining non-Medicaid funded services needed within and outside of the Medicaid arena and how these should be organized at the state/local level) or narrow (considering the organization and interface of non Medicaid services that are needed by Medicaid recipients only, without getting into a discussion of complete restructuring of state/local roles at this time)? This needs to be clarified prior to the June meeting.

Additionally since this is a time abbreviated process with just a few meetings over the summer, rather than brainstorming on the ideal system and needed services (whether for Medicaid only or all behavioral health service recipients), if the local services currently offered are shared in advance of the next meeting as requested above, along with model system of care documents for children, adults and older adults, we can have an efficient and inclusive discussion at our next workgroup meeting with a goal of clarifying those non Medicaid services needs that are most important to stakeholders. If it would be helpful for stakeholders to suggest model system of care documents prior to the next meeting, we can certainly do this and get back to you with unified recommendations from the MH Coalition on this point.

Finally, stakeholders recognize the tremendous amount of pressure this process is placing upon a very small core staff within DHMH. We view this exercise as a team effort and are ready and willing to assist in the collection of information or other functions that would be helpful in relieving some of this burden. Please do not hesitate to call upon us. The Maryland Mental Health Coalition is meeting every Friday morning by conference call to coordinate our efforts and I can relay any messages along these lines to our network as needed.

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Comment: I suggest that in presenting the data on use of inpatient care, that an additional line be added wherever inpatient data is presented with a break out of that portion of the inpatient care that is represented by a re-admission within 30 days of a prior inpatient admission. This is a very important metric that is currently used in the field and will be useful in informing the decisions about implementation of the model(s) of care we plan to use. Thank you.

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Comment: I think that there are three pieces of data which are missing from this grid:1. Dually Eligible Individuals should be separately identified (many individuals with mental health disabilities and an employment history are dually eligible) ; 2. Most frequented place of service should be identified by provide type and 3. Potential underestimate of substance use clients should somehow be established.

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Comment: The current ASO system provides the Mental Hygiene Administration with a wealth of timely and complete data. MHA has access to eligibility, provider, authorization, claims and Outcomes Measurement System data sets. Because the data are embedded in the financing system, data are complete and timely within the 12 month Medical Assistance timely filing limits. Individual consumer and provider information can be related across these data sets. Because many State funded services were also converted from a grants/contractual system into a fee-for-service system, reimbursement for those services became dependent upon the provision of and billing for them. That leads to at least two questions. 1. Will the behavioral health system provide reimbursement for State-funded services through its authorization and claims system since that is occurring today. The alternative, of course, is to return to a grant or contract service that will rely on some external reporting system that will have to be written, tested and implemented presumably by the time that the financing system is implemented. (I am assuming that since such services were taken off the discussion table, that the latter situation will be the one under which the system will operate-editorially, I feel this is a step back) 2. Will the same or very similar data be available across the behavioral health system AT LEAST for Medical Assistance funded services subsequent to the integration of services? It would seem essential to have such data and to be able to relate new data to historical data in order to evaluate the performance of the system, to implement and operate pay for performance programs, and, in the case of a protected carve out, to assure that the Medical Loss Ratio for behavioral health is maintained at required levels. While I have no personal experience with

the MCOs reporting of service encounters, reports that I have heard about maintaining the same level of data integrity and completeness may make it challenging.

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Comment: In his comments regarding the Evaluation Data at the May 1 meeting, Mr. Milligan referred only to claims based outcomes. Most of the national outcome measures as defined for behavioral health by the Substance Abuse Mental Health Services Administration (SAMHSA) are community focused and, in fact, not claims based. Both MHA and ADAA currently have systems that collect some NOMS data. Losing access to these data would have a serious negative effect on the evaluation of any behavioral health system that emerges, would make pay for performance and quality improvement initiatives and perhaps accreditation more challenging, and would likely put any future block grant funding in jeopardy as SAMHSA will likely continue to require that NOMS be collected and reported as part of block grant requirements. Additionally, it would seem that data collected through these mechanisms external to claims would be helpful in the process of the selection of a financial model.

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Comment: The data that are being examined for model selection have been limited to Medical Assistance claims and encounter data. There are other data sources that have data that is potentially very useful and actionable. The Mental Hygiene Administration does two annual consumer surveys, one for children and one for adults. While there may be a slight selection bias in which consumers elect to participate, the initial sample is a random one stratified only by region and the demographics of the respondents correspond closely to those of the PMHS participants. Questions are included about whether the consumer has a PCP (90% of adult respondents and 98% of child/caregiver respondents answered positively). There are additional questions regarding accessing the somatic health care system as well as questions regarding the need for, access to, and satisfaction with substance use services. Should not such data be relevant to and included in the decision making process? I can certainly provide assistance in obtaining the data and even completing some finer level analysis if that is warranted.

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Comment: Provide some opportunities for small business, increase competition in Health data sector. If ASO will still be used after the integration, I suggest at least part of Data reporting system should not be included in one whole RFP, in this way, some small business companies will have opportunity to bid, because several large ASOs which I have been working with or heard comments from county or providers were tremendously low efficiency, some reports could not deliver till the end of the contract, some small projects could spend 2 or 3 years even more to complete with 10 more people, which I can finish it just in 6 months by only myself, and also State should consider sharing some resource to County level or even provider level. My Medicaid Claim EOP reporting system may give you some idea. If you are interested in it, please go to <http://www.hhtdata.com/default.html>, all projects were finished by myself.

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Commenter: *de-identified*

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☒ Evaluation and Data
- ☐ Chronic Health Home

Comment: I am following the integration initiative with interest, but also with a little alarm when it comes to data.

I understand that the Federal NOMS system requires entry of data. However, the SMART system used by the ADAA has not been even slightly user-friendly, requires duplicate entry of data, and is simply not capable of meeting agency needs as an E.H.R. The recent initiative to consider upgrading SMART promises little - the reality is that multi-service agencies require customized E.H.R.'s that are capable of handling a wide swathe of information that will never be addressed by a "one-size-fits-all" SMART look-alike. With this in mind, I respectfully ask that, however the integration ends up being designed, the following principles be considered.

1. Agencies should be able to use their own EHR's to report data and should not be forced to duplicate data entry as is required under the current SMART system. The SMART system is notoriously difficult to use, and has very poor validity, because it is not tied directly to patient authorizations, and requires duplicate entry which under-resourced agencies do not have the ability to do reliably. The first solution to this problem is for the Department to lay out data specifications and allow agencies to build these into their E.H.R. systems rather than trying to develop its own e-reporting system.

2. Building on the above comment, it makes good sense for the required data to be delivered to the care management entity, rather than to a data system that is uninvolved in daily operations (as is now done with SMART). By making this data part of the care management/authorization system one assures that there is nearly 100% reporting, and that the reporting is relatively accurate because it is tied to the billing system. These are not characteristics of the existing SMART system, which is notorious in the provider community for its lack of validity. Using the OMS data as part of the authorization process has proven very successful in the PMHS, and it would be good to continue this model, tweaking it to allow agencies to upload specified data directly from their E.H.R.'s if they preferred to do this, rather than having to duplicate entry into a web-based authorization system. This would encourage agencies to use standard outcomes measures internally for ALL their funders, which would improve data quality and utility.

3. The data should be transferred to, presented, and analyzed by an independent, enduring, entity like the University of Maryland. It is extremely frustrating, and organizationally dysfunctional, to have to re-invent the data portal whenever care management is moved to a new entity.

4. In reading these comments, one might wonder what this has to do with the decision on how to proceed with integration. The reality is that the ability to generate good data in an efficient manner is a key variable, and should, I believe, be part of the evaluation of how to proceed structurally.

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Comment: 1. In addition to looking at the Maryland data that DHMH is assembling in the template formats distributed, I think it is critical to look at the national 2005 Medicaid data from other states that have implemented the various models we are considering. At the Children's Behavioral Health Policy Day on April 20, 2012, a distributed powerpoint presentation referred to the Faces Study that analyzed differences in utilization, expenditures and other measures among various state Medicaid management and payment arrangements (comparing Fee for service, capitated managed care etc.). This data should be very instructive in deciding on the model to choose in Maryland. One of the attendees, Rena Mohamed, said she has this data and will provide it. It may also be available through the Mental Hygiene Administration (who organized this event) or on-line. I have also seen references to this data as the Health Care Reform Tracking Project out of the University of South Florida. I have also seen references to the 2005 Medicaid MAX dataset.

2. At the meeting I suggested that the templates also break information down for people with developmental disabilities. I suggest that for template 2a and 2b, the data should also be broken down by whether a person has a developmental disability diagnosis (including intellectual disability, developmental delay, autism, any autism spectrum disorder such as pervasive development disorder or Asperger's syndrome, cerebral palsy, traumatic brain injury or any other serious physical disability that manifests before age 22). In addition to breaking the data down in all categories by MHD only, SUD only and both, columns should be added for a Developmental Disability Diagnosis (DDD) Only, MHD and DDD, and SUD and DDD.

For Table A listing the HEDIS Diagnostic definitions, the following should be added: ID, DD, Autism (PDD already included), Asperger's, TBI pre and post age 22.

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Comment: I believe this data from the Kaiser Commission should be considered by the workgroup in selecting a model:

The Kaiser Commission on Medicaid & the Uninsured has a 50-state survey of Medicaid managed care initiatives (including capitated MCOs and PCCM models):
<http://www.kff.org/medicaid/8220.cfm>

KCMU also issued a brief on Medicaid managed care for people with disabilities which contains a table summarizing key research at the end: <http://www.kff.org/medicaid/upload/8278.pdf>. Among the findings in that paper: Although risk-based managed care offers states increased budget predictability, managed care for persons with disabilities has not produced short-term Medicaid savings for states. Medicaid FFS payment rates, on which capitation rates may be based, are already so low in many states that there is effectively no room to extract cost savings by reducing price.

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Comment:

Below are comments regarding the collection of data and the data template distributed at the May 9, 2012 meeting:

- a. Data should be created by the state for these analyses and planning. The state should not try to collect the data from MCOs, CMHCs, or other groups. In part, the concern with collecting data from other groups is that there could be variability between groups that provide data.
- b. Information on diagnoses is critical (both MH and SA). If there are no data on diagnoses, then the exercise looking at state data may not be an effective use of time.
- c. Information on demographics will be helpful. Age should be provided in brackets, not as a mean age.
- d. Some metric of outcome (quality) should be included. This could be a patient satisfaction survey (at a minimum). Other measures, if available, would be good to have as well (e.g., hospitalizations, ED visits, etc.).

Thank you for the opportunity to provide comments.

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Comment: Because of the fee-for-service nature of the Public Mental Health System that was implemented in 1997, there is a good sense of the probable increase in demand for and cost of services as the population eligible for Medical Assistance increases. The grant based system that has been used for reimbursement for substance use services has not provided that same level of demand based data. How would the need for and cost of substance use services for the MA population be determined to establish the "protected" premium in model 1 or the behavioral health service system in model 2? Is it not possible and perhaps likely that the premium for substance use services will be understated if it is based on historical MA data and that resources that go into the system as a result of the better known demand for mental health services will have to be used to pay for substance use services?

Chronic Health Homes Comments

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Comment: I am the director of psychology at Mt. Washington Pediatric Hospital in Baltimore (a pediatric rehab and specialty hospital), and I found the meeting yesterday at UMBC very interesting. Unfortunately, I am getting involved late in the process, and I am trying to catch up as quickly as I can. I am particularly interested in this process and the chronic health homes. We specialize in working with children who have both chronic health conditions and behavioral health needs. We work closely with many of our populations here at our hospital, including children with traumatic brain injury, orthopedic conditions, asthma, diabetes, burn injuries, feeding and GI disorders, and obesity or overweight. We have found that many of these children and families have significant behavioral health concerns, and we work closely with these kids and their families to prevent and to ameliorate behavioral health problems. We are fortunate that much of their specialty medical care takes place here at our hospital, so integrating medical and behavioral care for these children and families is quite natural. Most of these children and families have Medical Assistance.

I am in the process of trying to figure out the best way for me to get involved in this process, and I will continue to read all the material you have made available and attend as many of the meetings as I can. When the time comes for discussion about specific diagnoses and the interface of chronic medical and behavioral conditions in children, I hope to be able to contribute.

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Comment: I also wanted to mention that the adult hematology group at Johns Hopkins has a HRSA grant to develop medical homes for adults with sickle cell disease. Below is a link to their website - there may be some information we can learn from/share with them regarding their model and how that might apply to health homes more generally.
<http://www.hopkinsmedicine.org/Medicine/sickle/>